

**APPLICATION FOR APPROVAL OF CONTINUING EDUCATION  
FOR ALCOHOL/DRUG ABUSE COUNSELORS**  
Training Provider/Sponsor Form

Training Provider/Sponsor: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street/P.O. Box) (City/State/Zip)

Provider Representative  
Completing Application: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

1. Program Title: \_\_\_\_\_

2. Program Date(s): \_\_\_\_\_ 3. Program Location(s): \_\_\_\_\_  
(Include All) (City, State)  
(a) \_\_\_\_\_ (a) \_\_\_\_\_  
(b) \_\_\_\_\_ (b) \_\_\_\_\_

4. Hours Requested for Approval (exclusive of breaks, meals, etc.): \_\_\_\_\_

5. How is this training alcohol/drug specific or relevant to alcohol/drug clinical practice: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Check below to indicate that each of the following items are attached:

- ☐ Description of the program content, objectives and methods of presentation.
- ☐ Agenda with outline of timeframes for instruction, registration, breaks, meals, etc.
- ☐ Names(s) of presenter(s) and resume, curriculum vita, or other documentation of each presenter(s) qualifications.
- ☐ Copy of certificate of attendance to be issued.
- ☐ Description of method for monitoring attendance.
- ☐ Verification that program is open to all alcohol/drug abuse counselors who meet program prerequisites.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Mail completed form with attachments to: Credentialing Division, Alcohol/Drug Abuse Counseling  
P.O. Box 94986, Lincoln NE 68509-4986

**For Division Use Only**

The above training is: Approved ☐ Denied ☐  
Hours Approved: \_\_\_\_\_ Approval Number: \_\_\_\_\_

Reason For Denial: \_\_\_\_\_  
\_\_\_\_\_

Division Authority \_\_\_\_\_ Date \_\_\_\_\_